CBAS Stakeholder Input Log

As Of: 04/17/14

			Submission Type		Submission Method			
Date Submitted	**Subject**	**Question/Input**	**Input**	**Question**	**Email**	**Meeting**	**Phone**	**Mail**
Stakeholder Kick-Off Meeting:								
10/23/2013	Access	Will we be able to look at the eligibility process of participants and if centers are taking care of the people properly?Will this program be able to be expanded to area where there are access problems?		1		1		
10/23/2013	Access	Not all counties have CBAS services-can this be addressed? Will the specialty model of ADHC be available through social services?		1		1		
10/23/2013	CBAS Program Model	Will CDA oversee the Plans? All participants will move into managed care?		1		1		
10/23/2013	CBAS Program Model	Cert Stds for CBAS process-Med aspect is not really complete, under the nursing part about administration process. This area should be under a pharmacist-maybe stds can be amended to ensure a pharmacist is involved.	1			1		
10/23/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	F2F-we're going to discuss in the process-are the nurses conducting the F2F to use their clinical judgment in the process; will we discuss who will do the F2F in the future?						
10/23/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	F2F ???		1		1		
10/23/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	F2Fwill this exist in the future?						
10/23/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	F2F outcome is getting longer to get	1			1		
10/23/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	F2F-not aware there are F2F issues-the caller can call LA Care.		1		1		
10/23/2013	Participant Information	Can link to slides be shared to we can send the slides to other? CBAS as a managed care benefit bars access to middle income people, how can we in the future provide this service to others that are not M/C beneficiaries.	1	1		1		
10/23/2013	Participant Information	There needs to be a public notice that these services are available for non-M/C individuals, also. Need to make it clearer on CDA webpage	1			1		
10/23/2013	Payments	Changing plans in the middle of the month, who's responsible for paying for the persons services and when should they be paid?		1		1		

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10/23/2013	Participant Information	Is it clear that everyone knows that ADHC services are still available? Can't access the presentation because of the costs.		1		1		
10/23/2013	Rates	Are we able in the process to look at rates? Can we secure a minimum rate since the plans may be able to lower the rates in the future?	1			1		
10/23/2013	Rates	Rates-impression that SNF needs to pay them the established M/C rates as they fold into managed care, CBAS is dealt with differently; will the CBAS rate be different than it is now? Will we have consumers as part of the workgroup?	1	1		1		
10/23/2013	Rates	Is the 76 per diem rate is to be paid by MCO? How to determine if a participant is a managed care plan member?		1		1		
10/23/2013	Rates	Will higher level of care individuals at the centers generate a higher rate?		1				
10/23/2013	Rates	Rates-gets higher acuity participants. How will the rate be reflected with caring for higher acuity participants?		1		1		
10/23/2013	Rates	Rates-What rate should we receive? Is there a way to cut the 10% back?		1		1		
10/23/2013	Rates	SB 97 cuts are being implemented now. Several centers closed because of the cuts	1			1		
10/23/2013	Rates	My question is about the rates for CBAS. The current rate of $68.64 is way below the cost of providing the service. This has caused many centers to close around us and more will follow. Our cost has been increasing by 10 to 15% every year (salaries, wages, gas, food etc.) but the Medi-Cal rate not only has not increased, but was cut by 10% last year. Please consider this very important fact to keep the CBAS program alive.	1	1	1			
10/23/2013	Stakeholder Process	Slide 19-What does ADHC participant protections and noticing mean?		1		1		
10/23/2013	Stakeholder Process	Will managed care participate in this process?		1		1		
10/23/2013	Stakeholder Process	Member of workgroup-is it in place or being defined right now? Which MCO will participate in the workgroup?		1		1		
10/23/2013	Stakeholder Process	No one in the past has providers to discuss how to change the program to make it more financially fit and program stability.	1			1		

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December 3, 2013 Stakeholder Workgroup Meeting								
12/03/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	TAR that is submitted with the IPC asking for the increment of the days (for 4 or 5x/wk) remained unanswered about 4 -5 months (L.A. Care). When I called them, they say, because MD should check the papers. For 2 or 3x/wk RNs check and they check it very quickly, but for 4 or 5x/wk MD should check, and it takes 4-5 months. This ironic part needs to be improved.	1			1		
12/03/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	1. Managed Plans have different policy and procedures, TAR submission requests, F2F r/t issues. That part need to be improved. They have to have unified requirements.	1			1		
12/03/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	The major part that should be improved it is CBAS TAR submission process. The managed care should have electronic file submission capacity. It is 21 century. I fax the TARs to the Health Plans, then I call them, then I confirmed that I faxed them, and then I send them the confirmation docs that I faxed them…..	1			1		
12/03/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	Issues with incontinence supply d/o managed plan, and also specialist referral by their PCP that they used to see. This area should be improved.	1			1		
12/03/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	Molina Plan's RNs used to call me every month for their participants and asked too many questions in order to complete their "report". I spend more than 30 min for each participants. What is going on with those plans? They are calling to participants with the same questions, and I have to say that the participants are not comfortable with those phone calls as well.	1			1		
12/03/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	I manage a center in a single payor county and they are very fast with face-to-face. I manage a second center in LA where we have a varitiety of wait times for face-to-face assessments.	1			1		
12/03/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	Has the Stste collected any information on the validity and relability of the currently used for the face to face.		1		1		
12/03/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	There needs to be someone who can help expidite changes for the critical preson who changes their MCO	1			1		
12/03/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	Wouldn't this be relevant if applied to the issue of participants changing plans & not having to wait to get a new F2F assessment?		1		1		

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12/03/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	Allowing centers to provide services outside of the center to transition participants after hospitalizations or SNF discharge would provide for less fragmentation of care by not involving other agencies i.e. Home Health.	1			1		
12/03/2013	Authorization Process and Face-to-Face (F2F) Eligibility Determination	In San Diego, we have a contact person to talk to at each plan. When we worked with MediCal FFS we did not have a contact person.	1			1		
12/03/2013	CBAS Program Model	It's hard to comment at the end of all of that. I do want to thank everyone for their participation. I think the ideas are really great and I particularly wanted to echo the sentiments shared by Lydia regarding flexibility and innovation and the Dr. Billl (sorry - missed his last name) regarding reimbursement and incentives.	1			1		
12/03/2013	CBAS Program Model	When you talk about flexibility in the model, we operate an activity center for DD adults with a nursing component for caring for DD persons with health care problems which would normally exclude them from attending an adult day program due to restricted conditions. The cost of the program is about the same as an ADHC/CBAS program, but instead of many professions, we provide nursing and a high staff:consumer ration of 1:3. We also provide social support and a rich activity program that meets individual needs.	1			1		
12/03/2013	CBAS Program Model	If regulations go away, Is there an opportunity to use the center's plan of operation as a way to determine if they are meeting care needs as they stated they would?		1		1		
12/03/2013	CBAS Program Model	Q: Then we need to insitute flexibility tied to plan of operation.	1			1		
12/03/2013	CBAS Program Model	Q: Hi, Raffie with Health Net. Nina and others have touched on key points around the fragmentation that exists. As a result, CBAS and other programs and services are not utilized to their full potential. The goal of CCI is to close these gaps. Unfortunately the fragmentation will continue if beneficiaries are encouraged to opt out and remain FFS. This workgroup certainly is the right start for a functional and coordinated path to a comprehensive psycho/social/medical model. Thank you.	1			1		

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12/03/2013	Information Technology	There should be a unified webpage where we can check the TAR status: let's say Health plan page Chose the plan, provider Check the TAR status. For now it is working only for Care 1st plan.	1			1		
12/03/2013	Not-for-Profit Provider Status Provisions	One big issue in modifying the 1115 waiver is the state''s insistence on nonprofit status for CBAS centers. But I haven't heard a word about that in Meeting #1. Has that requirement been jettisoned?		1		1		
12/03/2013	Not-for-Profit Provider Status Provisions	Medi-cal & medicare pay doctors, home health, nursing facilities and ... and they do not have a non profit req.	1			1		
12/03/2013	Not-for-Profit Provider Status Provisions	Non profit req. does not save money or improve quality of service. But It will hurt many centers who have invested alot of money to help the elders.	1			1		
12/03/2013	Rates	Another area for attention is the rural areas and the transportation. the need is huge yet the transportation cost is prohibitive. could the transportation cost be considering for reimbursement in certain counties?	1	1		1		
12/03/2013	Stakeholder Process	Excuse me if I do not understand the purpose of the working groups, but are you trying to identify the positive and negative spots of the CBAS???		1		1		
12/03/2013	Stakeholder Process	Q: Suggestion: You may develop a questionnaire with the essential questions r/t CBAS program and the waiver, and submit to the CBAS centers asking the PDs to complete those questionnaires and submit the responds to you. Be specific, include the comment parts, and put the deadline. Give us the chance to submit the responds by different ways: trough fax, e-mail etcc. Thanks	1			1		
12/03/2013	Stakeholder Process	Can you orginze the working group discussion in LA?		1		1		
12/03/2013	Stakeholder Process	How do we know that our voice would be considered? It was not considered when the CBAS was implemented instead of ADHC.		1		1		
12/03/2013	Stakeholder Process	Will we get updates on who is in each of the small workgroups?		1		1		
12/03/2013	Stakeholder Process	What is the best way for us to submit our comments on the matrixes - fax or email?		1		1		
12/03/2013	Stakeholder Process	I'd like to say how pleased I am with this process so far. I'm glad to hear so much input from those outside the workgroup and the fact that our input will be inculded to the workgroup.	1			1		

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12/03/2013	Stakeholder Process	Can you change the meeting times to make it easier for us to attend from southern california?		1		1		
12/03/2013	Stakeholder Process	What is difference between workgroup member and participant on this conf call? my cell phone as participant was muted.		1		1		
12/03/2013	Stakeholder Process	May also be helpful for the workgroup members to get the comments collected by CDA before the workgroup meeting so that they can look at them before coming to the meeting so they can work on the comments during the meeting.	1			1		
12/03/2013	Stakeholder Process	I think that people who are on the phone should also have the opportunity to call in and make a comment, not just those who are in the room.	1			1		
12/03/2013	Stakeholder Process	Stakeholder input-how will that be incorporated into the workgroups final recommendation?		1				
12/03/2013	Standard Assessments	Adding to Mark's Statement, the common assessment could be added to with various special subassessments for various populations.	1			1		
12/13/2013	Stakeholder Process	When will the revised matrices be available to stakeholders (in addition to the workgroup members)?		1	1			
January 9, 2014 Stakeholder Workgroup Meeting								
01/09/2014	Authorization Process and Face-to-Face (F2F) Eligibility Determination	How do we service beneficiaries whose medicare health plan is not one of the ones approved for CBAS?		1		1		
01/09/2014	Stakeholder Process	Can we move the meeting times to start at 1:30?		1		1		
01/09/2014	CBAS Program Model	The "community" is redundant. the facility is better suited since it's a day program	1			1		
01/09/2014	CBAS Program Model	I concur with Jane(?) said. The "facility-based" is what distinguishes us from Home Health services.	1			1		
01/09/2014	Stakeholder Process	Is this spreadsheet available on the CDA websight also so we can review it at our own pace?		1		1		
01/09/2014	Stakeholder Process	Please make sure the spreadsheet is reposted with today's updates.	1			1		
01/09/2014	CBAS Program Model	Centers provide BOTH rehabilitative AND maintenance services, not just maintenance.	1			1		
01/09/2014	Authorization Process and Face-to-Face (F2F) Eligibility Determination	Regarding the f2f -- Allow the managed care to reserve the right to provide a face-to-face, otherwise a face to face is not required prior to admission. (# 29)	1			1		
01/09/2014	Stakeholder Process	Do I have to use the telephone to join in?		1		1		
01/09/2014	Stakeholder Process	Will I able to obtain a copy of today's print out later after the meeting?		1		1		

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01/09/2014	CBAS Program Model	Why not say "CBAS is a program that delivers skiller nursing care, social services, therapies, personal care, etc.and transportaiotn to certain State Plan beneficiaires in an outpatient setting.	1			1		
01/09/2014	Stakeholder Process	Sorry I joined call late. Will the STC Matrix be made available on the website?		1		1		
01/09/2014	Authorization Process and Face-to-Face (F2F) Eligibility Determination	Again, sorry if this question has already been addressed because I joined the call late. Dual beneficiaries who are enrolled in D-SNPs without managed Medi-Cal contract, can they continue going to CBAS? Many are being denied CBAS services.		1		1		
01/09/2014	Access	Please keep in mind that not all counties have the CCI.	1			1		
01/09/2014	CBAS Program Model	Ideas about transportation: how about an approach if the transportation as a service to be excluded from the CBAS services under the current rate, however if the transportation is offered then additional payments are paid to CBAS center based on the following criteria: The number of centers in the area and the distance we have to travel to provide access to CBAS for eligible beneficiaries: in Ventura county we have to travel 40 mi to pick up some participants and not because they do not want to attend other centers, which may be closer, but because there is nothing in the area. We have to have 14 wheelchair accessible vehicles. The size of Ventura county is almost the same as LA county but the population is very spread thus in other counties centers having the same ADA have very different transportation solutions: their participants have options to use subsidized public transportation, some of them reside within short distance & in some instances in the same building where CBAS center is located	1			1		
01/13/2014	Stakeholder Process	Please allow sufficient time next time for public on conference call to comment. Thank you.	1					

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01/13/2014	CBAS Program Model	While listening to the CBAS STAKEHOLDER MEETINGS, I noticed that there were no provisions for providers in rural areas. The rural areas CBAS centers have major difficulties with providing access to care for eligible beneficiaries because of travel distances and population density. The average ratio of households in rural areas to households in urban areas is approximately 1:12. In Ventura County, we travel upwards of 40 mi to pick up some participants, and not because they do not want to attend other centers that may be closer, but because there is nothing available in their areas as a result of the financial impracticability of opening a center in an area with low population density. The size of Ventura County is about half of the size of the LA County, and has a population 1/12 (one-twelfth) the size, spread widely throughout the county. In order to provide access to care for all beneficiaries, we must have 14 wheelchair accessible vehicles. Conversely, in densely-packed counties, centers with the same ADA have an easier time finding transportation solutions, as their participants have the option to use subsidized public transportation, and some reside within short distance of or even in some instances in the same building as where CBAS center is located. Transportation costs have risen drastically due to increases in gas prices, insurance and labor cost. However, our rates have remained the same for almost 10 years. The current reimbursement rate has to be adjusted in order to properly reflect the astronomical transportation expenses associated with providing care for eligible CBAS beneficiaries in rural areas. Additionally, there are no provisions for providers caring for very low functioning CBAS members. Those participant in some instances require 2 staff members for personal care (like for example toileting or transfers) and one-on-one for feeding. Therefore, in order to facilitate greater access to care for such individuals and to offset the high cost of such case, there is a strong need for higher reimbursement rates.	1		1			
01/16/2014	Access	Why is there no transportation provided by the health plans on holidays during the weekdays for doctor appointments? Doctor offices are open and making appointments along with cbas centers. Major concern for our seniors!!		1	1			

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01/25/2014	Authorization Process and Face-to-Face (F2F) Eligibility Determination	Why is the Health Risk Appraisal required by the health plans not considered redundant with respect to the F2F. Asking the plans to do both seems to me to be an unnecessary and duplicative expense. Shouldn't the plans be allowed to determine eligibility any way they want to? After all they are the entity responsible for managing the care needs of their members (and controlling the dollars). I also suggest that the period of approval be extended from 6 months to 12 months. Virtually 100% of eligible CBAS enrollees are not going to get better and be discharged because they no longer meet the eligibility requirements. They are all slowly deteriorating. (Remember how many people determined to be ineligible in the 2012 CBAS transition period died within a few months?) Having a six month cycle is another waste of precious resources, spending time filling out forms instead of actually providing patient care.		1	1			
01/31/2014	Authorization Process and Face-to-Face (F2F) Eligibility Determination	The current IPC is not a "plan of care". The current IPC includes a plan of care but is the document used for (re-)authorization of services. It is a cumbersome, dated multi-page document that everyone agrees should be streamlined. I would suggest that the "care plans" be removed from the form all together. Problem- "Participant's BG ranges from 130-250 over last six-months. Participant states she does not follow diet because she eats when she is upset (depression) and doesn't have the opportunity to exercise outside of the center. Participant is 45% over ideal body weight, she states she would like to lose weight too." Goal—"Participant's BG will be between 100-130, participant will lose 5% of body weight and will exercise 3x per week, either in center or outside of center." Each discipline would then write an intervention to support the participant to reach her goal, such as; • Nursing; taking BG reading, providing education regarding diabetes management and praising participant's successes.	1		1			

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		• Social work; motivation to exercise, using food as a coping tool. • PT; exercise at the center. • Activities; movement, social stimulation/interaction to improve mood. • Psychological consultant; providing counseling/group to support participant's improved mood, decrease depression, teach coping skills. • Dietitian; education and proper diet at center. For authorization and re-authorization a new form can be developed, a form that contains the minimal amount of information required/desired for (re)authorization; perhaps by a separate workgroup that includes representatives from the MCO's, centers and State representative(s) to ensure that it covers only what is necessary and any extraneous information is removed. I suggest that the current "IPC" should no longer be used and an entirely new document created that provides only what is needed for authorization by the MCO's/state requirements. Minimally, I suggest that it no longer be called the IPC, as it is an authorization form. Which might help any confusion around a plan of care and an authorization form. The center develops care plans for the participant initially and every six-months based on a detailed and comprehensive assessment by each required discipline. These remain in the participant's chart. If the MCO would like to see the participant's care plan(s) or assessments, they can request a copy. This will cut down on the massive duplication that is currently occurring of paperwork and thousands of hours of time that could be better spent supporting participant's health and desire to remain in the community. Regarding expedited admission; give the MCO's the option to refer a participant "pre-authorized" for services. This allows for expedited admission and no delay in services. I would suggest strongly that a MCO has most of the basic information already, especially on participants who are high risk, that would be gathered and place on an "authorization" form. Assessments would still be provided by the center, as per regulation, but the participant could be admitted without any delays due to waiting for authorization. Regarding Care Planning and speaking to the conversation about how to ensure that the plan of care developed by the participant's MCO corresponds to the plan of care developed by the center; by developing a care plan in the following way, each entity is able to support the individual participant to the best of their respective abilities and a more effective, person based, measurable care plan is created. Goal Based Care Planning: • Care planning should be switched to a "goal" based plan of care, rather than the currently used "discipline" based plan of care. o This would enable the CBAS interdisciplinary team, MCO and other interested parties to better						

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		team, MCO and other interested parties to better function as a team to address the most pressing problems the participant is experiencing and to support the participant to remain in the community. o Approaching care planning in this manner also allows for improved person-centered care. o A goal based care planning approach would also enable the MCO and the CBAS center to develop, agree on and share the same goals for the participant. Allowing for better collaboration and continuity of care. The interventions used to support the participant to reach the goal would be different, as the MCO and CBAS center provide different services. Both entities would be able to develop goals for participants based on assessments and health information provided and gathered. o Goal based plans of care utilize the team approach to address the problem instead of individual disciplines each addressing their own identified problem individually (interdisciplinary approach rather than multi-disciplinary). o Example (using a person-centered approach) Problem- "Participant's BG ranges from 130-250 over last six-months. Participant states she does not follow diet because she eats when she is upset (depression) and doesn't have the opportunity to exercise outside of the center. Participant is 45% over ideal body weight, she states she would like to lose weight too." Goal—"Participant's BG will be between 100-130, participant will lose 5% of body weight and will exercise 3x per week, either in center or outside of center." Each discipline would then write an intervention to support the participant to reach her goal, such as; • Nursing; taking BG reading, providing education regarding diabetes management and praising participant's successes. • Social work; motivation to exercise, using food as a coping tool. • PT; exercise at the center. • Activities; movement, social stimulation/interaction to improve mood.						

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		• Psychological consultant; providing counseling/group to support participant's improved mood, decrease depression, teach coping skills. • Dietitian; education and proper diet at center. o In this manner, the participant and his or her goal(s) become the primary focus, and all team members can "attack" the problem from their own area of expertise creating better outcomes and better ability to track improvements. Both the MCO and the center can easily agree on the goal, but the center is allowed the freedom to address the goal in the best interests of the participant, as they will know what approaches will work best with the individual participant. o The plan of care should have a space for not only the interdisciplinary team to sign, but for the participant and/or caregiver to sign as well to support person-centered care.						
01/31/2014	Authorization Process and Face-to-Face (F2F) Eligibility Determination	Comment on Line #1: Facility based can be interpreted to mean that services provided originate or are "based" from a facility. Although services may be provided in the community through the cbas center, the origin of the services come from the facility—and the majority of the services do come from the facility.	1		1			

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01/31/2014	Authorization Process and Face-to-Face (F2F) Eligibility Determination	Comment on Line #29: An idea for expedited admission: Give the MCO's the option to refer a participant "pre-authorized" for services. This allows for expedited admission and no delay in services. I would suggest strongly that a MCO has most of the basic information already, especially on participants who are high risk, that would otherwise be gathered and placed on an "authorization" form generated by the center. Assessments would still be provided by the center, as per regulation, but the participant could be admitted without any delays due to waiting for authorization. In regards to the "face to face"; Write a statement that the managed care plans retain the right to require a face to face, but this is discretionary on the part of the MCO	1		1			
01/31/2014	Authorization Process and Face-to-Face (F2F) Eligibility Determination	Comment on Line 30: Re-authorization every 12 months for all participants, unless the MCO has a specific plan of services for less than 12 months. Assessments will continue to be completed and care-plans updated every six months as required by regulations. Individual MCO's may request paperwork for review of authorization, but this should be a discretionary choice of the MCO. This will save an enormous amount of time, finances and resources.						

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01/31/2014	Authorization Process and Face-to-Face (F2F) Eligibility Determination	Comment on Line #35: Regarding Care Planning and speaking to the conversation about how to ensure that the plan of care developed by the participant's MCO corresponds to the plan of care developed by the center; by developing a care plan in the following way, each entity is able to support the individual participant to the best of their respective abilities and a more effective, person based, measurable care plan is created. Goal Based Care Planning: • Care planning should be switched to a "goal" based plan of care, rather than the currently used "discipline" based plan of care. o This would enable the CBAS interdisciplinary team, MCO and other interested parties to better function as a team to address the most pressing problems the participant is experiencing and to support the participant to remain in the community. o Approaching care planning in this manner also allows for improved person-centered care. o A goal based care planning approach would also enable the MCO and the CBAS center to develop, agree on and share the same goals for the participant. Allowing for better collaboration and continuity of care. The interventions used to support the participant to reach the goal would be different, as the MCO and CBAS center provide different services. Both entities would be able to develop goals for participants based on assessments and health information provided and gathered. o Goal based plans of care utilize the team approach to address the problem instead of individual disciplines each addressing their own identified problem individually (interdisciplinary approach rather than multi-disciplinary). o Example (using a person-centered approach) Problem- "Participant's BG ranges from 130-250 over last six-months. Participant states she does not follow diet because she eats when she is upset (depression) and doesn't have the opportunity to exercise outside of the center. Participant is 45% over ideal body weight, she states she would like to lose weight too." Goal—"Participant's BG will be between 100-130, participant will lose 5% of body weight and will exercise 3x per week, either in center or outside of center." Each discipline would then write an	1		1			

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		☑ Each discipline would then write an intervention to support the participant to reach her goal, such as; • Nursing; taking BG reading, providing education regarding diabetes management and praising participant's successes. • Social work; motivation to exercise, using food as a coping tool. • PT; exercise at the center. • Activities; movement, social stimulation/interaction to improve mood.						
		• Psychological consultant; providing counseling/group to support participant's improved mood, decrease depression, teach coping skills. • Dietitian; education and proper diet at center. o In this manner, the participant and his or her goal(s) become the primary focus, and all team members can "attack" the problem from their own area of expertise creating better outcomes and better ability to track improvements. Both the MCO and the center can easily agree on the goal, but the center is allowed the freedom to address the goal in the best interests of the participant, as they will know what approaches will work best with the individual participant. o The plan of care should have a space for not only the interdisciplinary team to sign, but for the participant and/or caregiver to sign as well to support person-centered care.						

CBAS Stakeholder Input Log

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01/31/2014	Authorization Process and Face-to-Face (F2F) Eligibility Determination	Comment on Line #59: The language in this does not reflect the mental health services provided within the CBAS center clearly. It is a requirement to provide a referral to CMH for everyone with an "included" mental health disorder. Most participants though, choose not to accept the referral, and receive mental/behavioral health services at the center from a fully qualified and licensed mental/behavioral health provider. This provider will and can provide services to participants who are "experiencing symptoms that are particularly severe or whose symptoms result in marked impairment in social functioning".	1		1			
February 4, 2014 Stakeholder Workgroup Meeting								
02/04/2014	Stakeholder Process	How or Where can we access this spreadsheet so we can see it in its entirety instead of skipping around as we do during the call?		1		1		
02/04/2014	CBAS Program Model	Re: flexibility; currently all participants who attend a CBAS program must be provided all required services, and meet ALL eligibility requirements. There is no option for persons who don't need all of the services or who don't meet eligibility requirements. All or nothing. An option for flexibility is already in place; If a center has a dual program license (ADP/CBAS-ADHC), under the Adult Day Program (as opposed to the CBAS program) participants can be provided with a lower level of care. Potentially, centers who have a dual program license could contract with the MCO to provide only services that the participant needs and the MCO has authorized.	1			1		
		Example: the participant with dementia, who doesn't have major health needs, who doesn't meet the eligibility criteria for CBAS, but who is risk for LTC placement as he cannot be safely left alone. The MCO can contract with the ADP to provide activities and supervision, allowing the participant to remain in the community reducing all around health care costs.						
02/04/2014	CBAS Program Model	What services are considered to be unbundled? is transportation in rural areas one of the services?		1		1		

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02/04/2014	CBAS Program Model	Let me please confirm that i understand it correctly: so the transportation and the Physical therapy, Speech Therapy, Occupational Therapy, nurse case coordinator are considered to be unbundled? is it for all CBAS cenrers?		1		1		
02/04/2014	Rates	To add another question to the reimbursement: the minimum wage is going up this July and then in January. will this be factored too in to the reimbursement.		1		1		
02/04/2014	CBAS Program Model	It was not clear about the non-profit issue. is it going to be a condition to be a CBAS center or not?		1		1		
02/04/2014	Participant Information	Participants characteristics' questions definitely should be revised.	1			1		
02/04/2014	Stakeholder Process	Unfortunately I cannot share your amusement from those meetings. The biggest mistake/omission that your meeting was set and continues to be as you are now, is that you did not involve adequate professional staff directly from the centers. You need to hear our voices, but not for a minute during your discussion, but you need to conduct a survey as I told you before, with the essential questions. You need to design a right questionnaire (with the open- end questions too), conduct the survey, analyze, and come up with the conclusion.	1			1		
02/04/2014	CBAS Program Model	To be relevant in today's healthcare environment, we must align CBAS quality and outcome metrics with what the hospitals, SNF and MCO are measuring and interested in. For example... hospital readmission rates and diagnosis, etc. It looks like the CDA dashboard misses that completely.	1			1		

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02/05/2014	Stakeholder Process	I would like to comment on yesterdays workgroup meeting. Our program is designed for patient care. If we create more reporting and paperwork we will be taking time away from patient care! Our program was not set up like a hospital or clinic to have front and back office staff. If more reporting is required that would require more staffing resulting in higher costs. Our program has changed drastically merging with managed care plans. More time is spent on phone calls, faxing,billing issues,different requirement per plans etc.. Please lets not make requirements more complex and take away from patient care.	1		1			
March 6, 2014 Stakeholder Workgroup Meeting								
03/06/2014	Authorization Process and Face-to-Face (F2F) Eligibility Determination	Q: John Shen does not realize the continuity of care is more important than the eligibility determination by conducting F2F. The fact that participants have to wait 2-4 weeks is not "member" centered approach even for the plans.	1			1		
03/06/2014	Stakeholder Process	Q: Where can I print this CBAS Stakeholder Workgroup Recommendations Summary forms? I can't find it on CDA website. Thank you.		1		1		
03/06/2014	CBAS Program Model	Q: LA Care has not established a relationship with CBAS providers to install a monthly reporting procedure. LA Care needs to take a proactive approach in relationship with CBAS providers to make sure they communicate effectively.	1			1		
03/06/2014	CBAS Program Model	Q: Re:#12: CalOptima used to have Quality Assurance meetings with local CBAS Providers from 2012-2013, however, after 2 sessions, it was never resumed to develop any quantitative quality assurance measures to conduct "quality strategy" for CBAS providers.	1			1		
03/06/2014	CBAS Program Model	Q: Is CBHH more likely the combination of MSSP and CBAS program?		1		1		
03/06/2014	CBAS Program Model	Q: However, as contracted provider with CalOptima, we are required to submit monthly Characteristics, MSSR, Staffing info, and any incident reports to CDA.	1			1		
03/06/2014	CBAS Program Model	Q: Provider /Plan relationship is essential to new program implementation and transition. Important to have a venue for key partners coming together to facilitate transition.	1			1		

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03/06/2014	Stakeholder Process	Q: Sorry. (1) Quality Improvement, (2) Access, (3) Provider/Plan Relationship. Thanks. Viv	1			1		
03/06/2014	CBAS Program Model	Q: I'm a staff physician for a CBAS center. With our participants being more medically complicated and the shift to being more accountable for clinical outcomes, how do you see the staff physician role evolve? How much can I intervene in the participant's medical care? How will this impact the relationship with PCPs? Irina Kolomey, DO		1		1		
03/10/2014	CBAS Program Model	Dear John and Denise, per your request, I am sending you informal written comments along the lines of my public comment at the CBAS Waiver Renewal meeting on March 6. As I explained, Disability Rights California will submit written comments shortly, once the draft waiver submission is provided. In the meantime, based on the discussion and information provided at the March 6 meeting, I wanted to share the following comments. I have been impressed with the thoroughness of the stakeholder process and particularly with the amount of work that staff have clearly invested in making the information available and transparent to stakeholders. The discussions have been productive, informative, and inclusive of all workgroup members. I appreciated that time was allotted for a presentation of CBAS case studies and the health home project, both of which reinforced the importance of CBAS in California's long-term care system as a critical .	1		1			
		service which helps people avoid premature or unnecessary institutionalization and hospitalization. The concerns that I expressed involve what appear to be an erosion of the protections that exist in the Darling v. Douglas settlement, which exist in order to maintain access to CBAS for people who need it to remain in their homes and in the community. These concerns include:						

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		1. Rate "flexibility" for managed care plans: The Settlement includes a statewide minimum daily rate for CBAS, which can be adjusted upward by DHCS or managed care plans. A number of programs have already closed due to the 10% rate cut and an inability to remain operative under the current rate system (under which DHCS has not, and few plans have to date, agreed to raise rates, even in the face of program closure). Allowing plans to "pay CBAS providers based on acuity" can therefore only mean that plans will be able to negotiate rates downward once the settlement and the current waiver expire. This will lead to a decrease in access and quality of services as undoubtedly, plans will be incentivized to contract with the lowest bidders and CBAS programs providing higher quality (and higher cost) services will be forced to close their doors. We recommend maintaining the statewide minimum rate provisions.						
		2. Enhanced Case Management for Class Members: I understood that about 500 Darling Class Members receive Enhanced Case Management (ECM), and that the intention is to eliminate ECM when the Waiver is renewed. While we understand that managed care plans have some care coordination obligations, we recommend that ECM remain as a Waiver service for Class Members, even once the settlement expires, given their current, demonstrated need for this service.						

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		3. "Plan/provider Relationships": The discussion about this broad topic seems to include local implementation in the areas of contracting with CBAS providers, rate negotiation, and timelines and processes for eligibility determinations, service authorization/planning, and discharge planning and reporting. While these topics require further detail in order for us to provide meaningful comments, I once again urge that the Waiver renewal include statewide minimum protections in these areas in order to ensure that individuals have timely access to CBAS, that their services are authorized consistently according to the eligibility and medical necessity requirements, and that their access to quality CBAS services is not undermined by too much local "flexibility." □						
		In addition, while the current eligibility and service authorization process merits rethinking to remove duplication and steps that cause unnecessary delay, we recommend that important protections remain or be added to the Waiver renewal. These include: maintaining the requirement that a face-to-face assessment be conducted before denying or reducing services; the ability to conduct emergency/expedited assessments in certain circumstances; the ability for plans to authorize services on a conditional basis pending full assessment (and pay CBAS providers retroactively in order to prevent delay in initiation of services); and continuity of care provisions so that when a CBAS participant changes managed care plans, she does not experience a gap in services ("portability" of CBAS eligibility and authorization, at least until a new assessment can be completed). □						

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		4. Unbundled CBAS services: The settlement provides for managed care plans to authorize (and be compensated for) "unbundled CBAS" when a CBAS program closes and the participants do not receive services at another CBAS program. I understand that the intent is to eliminate this service. We recommend continuing this service as follows. Given the large number of counties in which CBAS does not exist, we recommend that "unbundled CBAS" be available to all individuals who are assessed as meeting the eligibility and medical necessity requirements for CBAS and who are determined to need and want the service, notwithstanding the unavailability of a CBAS program in their geographic area. At a minimum, however, we recommend that unbundled CBAS remain a covered service for Class Members whose CBAS program has closed, and for individuals whose CBAS programs may						
		close in the future. While we understand that managed care plans have some flexibility to authorize services to help their members, including unbundled CBAS as a covered service and in the rate structure will increase the likelihood that individuals who need unbundled CBAS will actually receive the level and type of services that otherwise would have been available to them at a CBAS program. Thank you for the opportunity to comment. I look forward to further developments in the waiver renewal process and the opportunity to provide further comments.						

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03/21/2014	CBAS Program Model	Dear Department of Aging, I am writing to you in order to give feedback, suggestions, and express concerns about Community Based Adult Services waiver renewal. First, I have to commend the working group on how they are handling this process. They are considering and addressing a number of issues and including the needs of individuals with special healthcare needs which gives me hope as an advocate for the survival of CBAS formerly, Adult Day Health Care Services which I fought to save and protect. I had a grandfather with dementia who participated in a local Adult Day Health Care day program which I had the opportunity to visit. This program was important to our family providing respite and care for my grandfather. I want all seniors with a need to access these services.	1		1			
		As you know, California is experiencing a huge growth in it's senior population. Now, the state is faced with how to best provide care and services for seniors. Unfortunately, I am concerned that the state is not prepared to provide high quality community based programs and services for seniors due to the ongoing budget crisis and cuts to many of these programs seniors will continue to need. It is important for the Governor and the Legislature to provide increased funding and investment in CBAS. I do agree that CBAS is an important solution to provide care for seniors and people with disabilities. CBAS needs to grow and be more accessible for seniors and people with disabilities. It needs to be a centerpiece in our healthcare system that providers will recommend first for caring for this population.						

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		In order for CBAS to be accessible for individuals that need it, CBAS should be available for individuals that are both in Medicare managed care and fee-for-service. Seniors and people with disabilities should have a choice in what services and supports are available and how their services are delivered. CBAS is known as the "best kept secret" in healthcare which concerns me because seniors and people with disabilities are not being told by their managed care plan or healthcare providers that it is available to them. CBAS should not be a "secret" but a program every healthcare plan, healthcare provider and other agencies providing community based services, more importantly their employees should know about.						
		I hope one of the main objectives of renewing the CBAS waiver besides expanding it is also a plan of outreach to inform as many healthcare plans, healthcare providers, community based services agencies like(independent living centers, senior services centers, those serving ethnic communities, and disability services providers) to let them know about CBAS as a important program in caring for seniors and people with disabilities. The state is beginning the Coordinated Care Initiative in six counties where most healthcare services will be accessed through managed care including CBAS which will be a key component of CCI however, due to the fact that CCI is on a trial run and it is not guaranteed to be available past the trial run; it is important that CBAS remain a stand alone program. If there are changes to CCI, then CBAS will still be able to provide care via managed care plans, CBAS centers, and Medicare fee-for-service for those that need the program. This should be clearly defined in the waiver language.						

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		CBAS should be a model for how senior care services are administered and delivered. It is essential that providers and managed care plans have clear communication about what care and services a CBAS participant will need and that the services and care are provided in a timely manner. The waiver should specifically state guidelines about communication between providers and care plans. The last concern I have is about managed care plans providing CBAS to eligible individuals. I am concerned that managed care plans may deny eligibility to CBAS as a way to cut cost or keep cost down. I am concerned that managed care plans have too much discretion that may impact individuals who need CBAS may not recieve it. That's why proper oversight by the state is so critical. I am concerned that waiver language would not be strong enough to protect seniors and people with disabilities from being denied access to CBAS.						
		We need to be prepared for huge growth in the senior population and how to best meet their care needs. The Governor is too concerned about cutting cost instead of investing in a model of care(CBAS) that will save the state money and provide high quality services at the same time. Thank you for your consideration.						
April 10, 2014 Stakeholder Workgroup Meeting								
04/10/2014	Stakeholder Process	is there going to be a transcript for this webinar?		1		1		
04/10/2014	Stakeholder Process	will you kindly send an email regarding the availability of the transcripts please		1		1		
04/10/2014	CBAS Program Model	Will eligible Darling class members continue to receive ECM? We recommend that ECM remain as a waiver service given these individuals' current, demonstrated need.		1		1		
04/10/2014	Rates	I'm submitting several comments and questions, on behalf of NSCLC and also the Darling class members. 1: we share others' concern about the need to preserve (and in the longer term, raise) the current rate floor after the settlement agreement expires. I'm still not quite clear about what will and will not addressed in the waiver, and would appreciate a more detailed explanation of this. How will the state ensure adequate funding to prevent an erosion of access and quality of services?	1			1		

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04/10/2014	CBAS Program Model	Will the waiver renewal include statewide minimum protections in areas like managed care contracting, service authorization and planning, and discharge planning and reporting? We recommend these protections be developed and preserved.		1		1		
04/10/2014	CBAS Program Model	I also had a question that wasn't answered about unbundled services-- would those be available to all Medi-Cal recipients, or just those currently receiving them? Thanks, Anna		1		1		
04/10/2014	CBAS Program Model	We appreciate and strongly support the workgroup recommendation to preserve unbundled CBAS. I can't quite tell from the summary if unbundled services will be preserved as a distinct plan benefit where applicable. If it is preserved, will it be available to all Medi-Cal recipients, or just those currently receiving them?		1		1		
04/10/2014	Stakeholder Process	when wil we know what happens		1		1		
04/10/2014	Stakeholder Process	will these slides be online		1		1		
04/10/2014	Rates	the whole rate reduction from last budget is that a trailer bill		1		1		
04/10/2014	CBAS Program Model	is making sure that that cbas is ada title 24 compliant centers and health plans know this too	1			1		
04/10/2014	CBAS Program Model	I agree with the current recommendations outlined in the screen now. It really does reflect what is needed to be revised regarding day to day operations at the center. Thank you!	1			1		
04/10/2014	Participant Information	Can you add a column on the number of participants and/or ADA served monthlty?		1		1		
04/10/2014	Rates	i would like to bring your attention the flexibility issue as well as the rates issue. as Alisa Gershon warned us during prior meetings and i absolutely agree with her, the rates and flexibility will open a door for Plans to choose a lowest bidder and thus it will jeopardize quality of service and will put providers with higher acuity participants out business as well as will create problems for certain beneficiaries to have an access to care.	1			1		
04/10/2014	Stakeholder Process	What are the chances of the new STC and SOP of getting disapproved by the CMS? Are we not running out of time? Will there be interruption of services?		1		1		
04/10/2014	Stakeholder Process	I missed the answer to whether or not the waiver could be extended temporarily after 8-31-14?		1		1		
04/10/2014	CBAS Program Model	I agree with the comments made by other stakeholders and suggest that Plans make a better effort of reaching us to include us in the development of procedures and rules.	1			1		

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04/10/2014	Stakeholder Process	What is the nature of the delay and when will they be available?		1		1		
04/10/2014	Stakeholder Process	Just in case more time is needed, can CMS extend the current waiver past August 31, temporarily?		1		1		
04/10/2014	Stakeholder Process	Given that the stakeholders have participated in good faith, can we get some asurance that the STCs will be processed and made available for comment before May? The timeline sounds vague.		1		1		
04/10/2014	Stakeholder Process	Survey monkey is a great idea given the short timeline. Will the submission to CMS be released to the public after the public comment period? and we will see the final draft?? or does the process go back to internal back and forth only?		1		1		
04/10/2014	Stakeholder Process	Ok that helps, I think people need to know that we only get to see the draft sent to CMS but after that the process becomes an internal one between CMS and DHCS.	1			1		
04/10/2014	Stakeholder Process	In the process of changing/amending the SOPs and STCs there could be unintended/unforseen consequences or policies/procedures that are discovered not to work or work against the member/provider/plan. It was stated that the next time this waiver will be reviewed is late 2015. Are there avenues for resolving these problems - should they occur- quickly?		1		1		